Health for All Steering Committee -- Policy Options
February 9, 2007

The following document briefly outlines various health policy proposals which may be conducive to legislative action this session. These proposals are being advanced by the Governor, KHPA, the Senate, and the House (more detail is provided in the attached materials). As this list is by no means comprehensive, several additional policy proposals are included. Additional policy options may be considered by the Steering Committee.

Governor Sebelius: Health Initiatives

1. **Zero to Five**. Promoting access to universal health care for children ages "Zero to Five" – this is an investment in our future that both promotes positive health outcomes and saves the State dollars in the long term.

2. **Health Information Technology/Exchange (HIT/HIE**). Building on the work of the Health Care Cost Containment Commission and the KHPA staff, the state should establish an Implementation Center for HIE in Kansas through a public/private entity as a single coordination point for Kansas HIE efforts. Responsibilities include: coordinating and tracking the day-to-day activities of HIE efforts; providing or engaging technical assistance and subject matter expertise; developing and offering tools, such as the HIE Guidelines to assist with the formation of Regional Health Information Organizations (RHIOs); assisting with legal and regulatory interpretations; providing a repository of lessons learned from HIE efforts across the state and the region; and have the ability to receive state funds and apply for non-governmental financial support for Kansas HIE planning and implementation efforts.

3. **Expand insurance to young adults through their parent policies.** Currently, dependent children of state employees who are under the age of 23, receive half of their support from the state employee, and do not file a joint tax return with another taxpayer, can receive health insurance through their parent's policy. Extending the age of dependency could cover more young adults in the state. Change the age from 23 to 25 and mandate that private insurers also provide coverage to dependent. In Utah, for example, a dependent may not age-out of health care coverage until their 26th birthday, regardless of whether or not they are enrolled in school. New Jersey enacted a law that provides coverage for dependents until their 30th birthday, as long as they have no dependents of their own. States have also expanded the definition of dependent. At least four states recognize grandchildren as dependents.

4. **Consider DRA Flexibilities**. The DRA allows moving waiver services into the Medicaid state plan, designing benchmark benefit packages with more cost sharing, and exploring innovate reform models through Medicaid Transformation Grants. KHPA is currently working with KDoA and SRS on developing plans to utilize DRA flexibilities – flexibilities that the federal government has only recently provided regulations. These should be will be included in a comprehensive reform plan.

Board Approved KHPA Policy Initiatives

Plan for Improving Access:

5. **Zero to Five**. Supporting Governor's Initiative (See #1.)

6. **Disproportionate Share for Hospitals (DSH) Reform**. Reform DSH to increase access to care for the uninsured and maximize the use of federal dollars. May be tied to premium assistance reforms (See #27).

7. **Medicaid and SCHIP/HealthWave Sustainability**. The KHPA is concerned about federal reforms that mandate new citizenship verification documentation. These changes have resulted in a decrease of 18,000 to 20,000 in our Medicaid and S-CHIP/HealthWave caseloads. We have shifted as many resources as possible to help at the Medicaid Eligibility Clearinghouse, have asked for more funding for staff this legislative session, are communicating with our federal delegation, and are working with safety net clinics to help access health services for those who are unable to quality for Medicaid and HealthWave services.

8. **Medicaid Outreach and Enrollment**. **Description:** Expand the marketing of programs available to the public in order to educate Kansans about the Healthwave program and health and wellness through: (1) designing an online application and screening tool for potential beneficiaries, (2) developing and implementing a targeting marketing campaign and (3) employing additional outreach workers. (Supported by Senate Task Force and other legislative leadership, See # 18).

Plan for Improving Quality:

9. **Health Information Technology/Exchange (HIT/HIE**). Supporting Governor's initiative (See #2)

10. **Transparency.** Promote Transparency for Kansas Consumers and Purchasers through a two phased approach that collects data currently available in one convenient location (through KHPA and State libraries), and then adds health care pricing and quality data (as determined by the Data Consortium – made up of providers, consumers, and purchasers). This kind of information will also help to reduce utilization of care that is not evidence based or is of questionable quality, which can serve to reduce overall health care costs.

11. **Data Driven Policy.** Promote Data Driven Policy through the funding of a Data Analytic Interface. This will allow the State to utilize the best data and evidence to inform policy choices that have the greatest potential to have a sustainable impact on reducing health care costs. Kansas is a state that is "data rich" – we have powerful information on private insurers, hospitals, Medicaid, the SEHBP, immunization registry, etc -- but we are sometimes "information poor" because these data sets are not merged in a way that allows for thorough analysis of health policy trends. These data are vitally important in developing a coordinated statewide health policy agenda. In addition, we need this data in order make decisions about

the management of health care benefits for Medicaid/SCHIP beneficiaries and for state employees, while balancing access, cost, and quality.

Plan for Increasing Affordability and Sustainability:

12. **Health Insurance Exchange**. A model for an "Insurance Exchange" in Kansas should be developed for Kansas. An entity such as the Connector which serves as a clearinghouse to facilitate the pooling and purchasing of health insurance could facilitate access to health insurance products by small employers and individuals. Certain elements of the Massachusetts Connector model, however appear to be fundamental to that goal; subsidies for low income workers, a mechanism to pool payments from multiple payers, variation in plans, use of pre-tax dollars for health insurance purchase, plan quality verification, and establishment of an adequately financed infrastructure. (Supported by Senate Task Force, See # 21).

13. **Reinsurance.** Analyze the potential for reinsurance, in partnership with Commissioner Praeger and the Business Health Committee. Using a reinsurance mechanism similar to that of Healthy New York, premium volatility in the small group market can be reduced. The increased predictability in premium trends and lower costs could significantly expand coverage to small employers and sole proprietors. State subsidies for reinsurance could also work to reduce premiums and increase insurance coverage in the individual and small group market. A recent study commissioned by Praeger modeled four mechanisms of reinsurance using KHIIS data which showed that 5% of the insured small employer population accounted for 62% of the claims incurred in that market.

Plan for Improving Health and Wellness:

14. ***No Legislative Action Required:*** **Promoting Health and Wellness through the State Employee Health Benefits Plan**. The SEHBP is being re-designed to be a model for employers across the state by promoting health and wellness initiatives that encourage individual responsibility for health behaviors. This does not require spending new SGF as the funds are already contained within the SEHBP and an RFP for the provision of these services will be available soon. Supported by Governor.

15. **Health and Wellness in the Medicaid and S-CHIP/HealthWave**. KHPA has explored additional health and wellness initiatives for Medicaid beneficiaries as outlined by the submitted FY 2008 budget, including paying for weight management physician visits, integrating Medicaid immunization records with KDHE, and a request for funding to study and implement health promotion programs for Medicaid beneficiaries. The Governor supports this initiative.

Plan for Improving Stewardship:

16. **Complete Agency Staffing**. The KHPA needs to complete its staffing in order to meet its statutory mission. This includes adding 42 new staff to the agency, with an additional number of staff added to the Eligibility Clearinghouse (both agency and contract staff). The

Governor provided support in her budget for approximately half of the staff positions.

Plan for Improving Education and Public Engagement:

17. **Creation of Advisory Councils.** The Board will be announcing at the February Board meeting the creation of three Reform Councils (Provider, Purchaser, and Consumer) to provide key stakeholder input on broad "blue sky" policy initiatives that address improving health and wellness, increasing access, improving quality, and increasing affordability and sustainability. Each of the reform councils will be staffed by the KHPA. These specific proposals will then be combined and presented to the KHPA Board for consideration.

Senate Task Force Initiatives

18. **Children First.** Currently, there are 46,000 uninsured children in Kansas. However, 71% already qualify for existing programs, but do not use them. The Task Force supports enhanced efforts to increase participation in these programs by the use of on-line enrollment and expanded outreach programs targeting populations that qualify for these benefits. (Supported by KHPA, See # 8).

19. **Prevention Pays.** The leading cause of preventable death and illness in our State is related to the use of tobacco. The Task Force supports a comprehensive tobacco prevention program for Kansas. Beginning April 2008, an additional 15 to 16 million dollars will be available to Kansas from the Master Tobacco Settlement Agreement. The Task Force supports committing the use of those funds to develop a comprehensive program based on the successful model authored by the Center for Disease Control and commit to a ten year program. The Task Force therefore encourages the passage by the 2007 Legislature of Senate Bill 318.

20. **Early Detection.** The Task Force supports expanded screening for newborns from our current level of four tests to twenty-nine. This effort represents a true and meaningful step in the direction of early diagnosis and early intervention that will pay immeasurable benefits in future years. This initiative is supported by the Governor.

21. **Kansas Healthcare Connector.** The Task Force recognizes the need for significant health care reform in the market place. Minor nudges or tweaks to the current system will not be enough. The Task Force supports the following changes: (1) Increased portability and ownership by individuals of health care policies; (2) The use of pre-tax dollars to purchase health insurance whenever possible; (3) Expand the role of the consumer in health care decisions; (4) Using federal dollars to subsidize premiums, realizing the Congress is looking for States prepared with innovate ideas for insuring low income families.

House Republican Task Force Initiatives

Not yet introduced.

Other House and Senate Initiatives

22. **Expand access through SEHBP buy-ins.** Currently a limited number of school districts and municipalities are participating in the SEHBP buy-in program. Review the qualifications and underwriting criteria for the existing buy-in option for non-state public employees to encourage additional participation by schools and municipalities. Some teachers in the State of Kansas pay as much as $800 per month for health insurance premiums. A rigorous analysis is needed of the State Employee Health plan to determine ways in which to ensure affordable health insurance may be offered.

23. E**xpand insurance to young adults through their parent policies.** Supporting Governor's initiative (See #3).

24. N**o-interest loans to small businesses to start group coverage.** House Democrats propose to allow small businesses to apply for no-interest loans through the Department of Commerce that would help pay the start-up costs of establishing group health insurance coverage. Currently, the high start-up cost for establishing a new purchasing group for discourages small businesses from collaborating with one another. This proposal would give businesses an opportunity to pool resources and create a larger pool for group coverage and therefore increase their purchasing power. By joining with other businesses, business owners will be able to provide affordable options to their employees with coverage of preexisting conditions at a much lower cost than a small group policy.

Additional Initiatives to Consider

25. N**eed for Economic Impact Analysis for Coverage Expansion.** In addition to stakeholder input, an economic modeling analysis of various policy options to improve access to health coverage in Kansas is needed. Such an analysis is necessary to understand how different policy proposals affect coverage changes (in public programs, employer sponsored insurance, directly purchased insurance, and the uninsured) as well as spending by payer (State government, federal government, families, employers). This information is critical in helping to determine which proposals are most feasible in Kansas. Two foundations, one national and one Kansas-based, have expressed interest in funding such an analysis.

26. C**onsider Deficit Reduction Act (DRA) Flexibilities**. Supporting Governor's initiative (See #4). The DRA allows moving waiver services into the Medicaid state plan, designing benchmark benefit packages with more cost sharing, and exploring innovate reform models through Medicaid Transformation Grants. KHPA is currently working with KDoA and SRS on developing plans to utilize DRA flexibilities – flexibilities that the federal government has only recently provided regulations. These should be will be included in a comprehensive reform plan.

27. P**remium Assistance**. Some states are moving toward a premium assistance model which is meant to encourage low-income families' participation in private coverage, shore-up the private coverage market and prevent crowd-out, and achieve cost savings by bringing in employer contributions to help offset costs. Premium assistance programs use federal and

state Medicaid and/or SCHIP funds to subsidize the purchase of private health insurance. They may also utilize employer or enrollee contributions to help pay premium costs. Some premium assistance models provide "wrap-around" coverage to the employer sponsored plan. Premium assistance models could be developed in tandem with a Health Insurance Exchange model. (Supported by Senate Task Force, See #21).

28. M**ove to a wellness payment incentive model.** Measure the health and wellness outcomes of physicians with Medicaid PCCM panels. Provide cash bonuses for improving the health status of patients assigned to the PCCM. Provide incentives (technology payments, special training, infrastructure grants) to physicans or practices that demonstrate high quality care.

29. **Strengthen existing small business initiatives.** Currently a small employer tax credit and the Business Health Policy Committee provide underutilized mechanisms capable of improving access to health insurance for a population of over 75,000 uninsured working adults in Kansas. The tax credit has underperformed due to continued administrative complexity, lack of public visibility, and it's temporary nature. The Business Health Policy Committee developed a benefit package, secured bids on that package, and proposed a pilot subsidy project for low-wage workers in Sedgwick county but implementation was halted due to lack of FY 2007 funding. This initiative taken statewide has great potential to reach a large segment of uninsured Kansans.

30. P**romoting a "Buyer's Group" for health insurance.** Kansas could create a Buyers Health Care Group similar to the Minnesota plan which is one of the best-known employer health care purchasing coalitions in the country. The goal of a Buyers Health Care Group is to spur employers, health care providers, government leaders, insurers and consumers to think about and purchase health care services differently. Employers in the BHCAG coalition combine their purchasing power and work closely with health care providers and administrators to create a health care delivery method that provides access to quality, cost-effective care for employees and their families.

31. I**mplement the subsidized Business Health Policy Committee's Small Employer Health Insurance Program.** Employers who have not offered health insurance for two years would have access to an administratively simple and comprehensive health insurance plan available through the Business Health Partnership with subsidies available for employees with family incomes below 200% FPL.

32. I**ndividual mandate.** The provision of employers sponsored insurance (ESI) continues to decline across the US and is linked to the increasing number of uninsured, currently at an all time high. Several states seeking to achieve universal coverage are considering individual mandates (such as that passed in Massachusetts) given the regulatory difficulty of passing employer mandates (employer sponsored coverage being largely regulated through ERISA). There are different means by which to mandate individual policies and employer requirements are often coupled with the individual mandate. Employers can either be required to provide a "modest employer assessment" of a specific amount (such as $400) per worker per year such as in Massachusetts. Or, employers can be required to "pay or play" – requiring employers to either offer health insurance coverage to their employees or to pay a

specific amount (usually a percent of payroll) to help subsidize those who don't have employer sponsored coverage. Should Kansas wish to achieve universal coverage, an individual mandate should be considered and analyzed.

33. **Intensive health insurance outreach to Hispanic population.** Over seventeen percent (42,500) of uninsured Kansans are Hispanic and research has documented that there exist a number of factors that contribute to this situation. In addition to being disproportionately low-income, the Hispanic population nationally also has less familiarity with the concept of health insurance and is distrustful of it's utility. An intensive outreach campaign outlining the importance of health insurance in improving access to health care coupled with other policy initiatives could reduce the number of uninsured Hispanic Kansans.

34. **Extension of Community Health Record Pilot Project Statewide.** The KHPA currently has a pilot program for a community health record (CHR) for Medicaid managed care providers in Sedgwick (SG) County. The CHR is built on administrative claims data and provides clinicians electronic access to claimed medical visits, procedures, diagnoses, medications, immunizations and lead screening data. We are currently working to enable the transfer of lab results to the CHR. The CHR also has an ePrescribing component that provides a drug interaction and contraindication tool, along with formulary information for the prescriber along with the capability to submit prescriptions electronically to pharmacies. We could expand the CHR concept statewide through a competitive bidding process.

35. **Developing Additional Pilot Programs.** Consider other pilot projects in a phased deployment of promising reform solutions in poor health status areas of the state. Assuming that the introduction of new methods and interventions may be somewhat complicated, results could be monitored more easily and adjustments provided more quickly in a phased setting without potentially large-scale disruption.